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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Outpatient Hospital Therapy Providers

HMOs and Other Managed Care Programs

Requirements for Therapy Evaluations and Re-Evaluations Provided During Outpatient Hospital Specialty Clinic Visits

The changes to reimbursement rates and program requirements for outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services (as indicated in the December 2005 *Wisconsin Medicaid and BadgerCare Update* [2005-74], titled "Changes to Reimbursement and Program Requirements for Outpatient Hospital Therapy Services") do not affect PT, OT, and SLP evaluations and re-evaluations provided during an outpatient hospital specialty clinic visit.

For a PT, OT, or SLP evaluation or re-evaluation to be considered part of a specialty clinic visit, all of the following must be true:

- The PT, OT, or SLP evaluation or re-evaluation is provided as part of a multi-disciplinary approach and cannot be separated from the specialty clinic visit.
- The purpose of the specialty clinic visit is to diagnose or determine treatment recommendations for the recipient or to provide periodic follow-up re-assessment.
- The visit is provided in an outpatient hospital facility. (Refer to "Outpatient Hospital Services" in this *Update* for more information about outpatient hospital services.)

Examples of Specialty Clinic Visits

A PT, OT, or SLP provider may be part of a specialty clinic team as in, but not limited to, the following examples:

- Physical therapy providers may be involved in cerebral palsy clinics, orthopedic clinics, pulmonary clinics, and wound care clinics.
- Occupational therapy providers may be involved in seating and positioning clinics, spina bifida clinics, cerebral palsy clinics, and rheumatology clinics.
- Speech and language pathology providers may be involved in cleft lip and palate clinics, Down syndrome clinics, saliva control clinics, and feeding clinics.

Requirements for Evaluations and Re-Evaluations Provided During Specialty Clinic Visits

When providing a PT, OT, or SLP evaluation or re-evaluation as part of a specialty clinic visit, providers should note the following:

- Prior authorization is not required.
- The PT, OT, or SLP evaluation or re-evaluation may not be reimbursed separately from the specialty clinic visit. Claims for specialty clinic visits may be submitted using the 837 Health Care Claim: Institutional transaction or UB-92 paper claim form and the appropriate specialty clinic revenue code. Reimbursement for

the revenue code includes all medically necessary services that are provided as part of the specialty clinic visit. Providers should refer to HFS 101.03(96m), Wis. Admin. Code, for the definition of medically necessary.

Outpatient Hospital Services

To be certified and reimbursed as an outpatient hospital by Wisconsin Medicaid, a facility must be licensed as a hospital by the Division of Disability and Elder Services, Bureau of Quality Assurance (BQA) under ch. 50, Wis. Stats. Therefore, a PT, OT, or SLP evaluation or re-evaluation may be reimbursed as part of an outpatient hospital specialty clinic visit *only* if it is provided in a building that is licensed by the BQA as a hospital. For licensure purposes, the hospital includes all inpatient rooms, surgical suites, and other facilities where services are performed for inpatients.

Wisconsin Medicaid's reimbursement methodologies differ from the methodologies of the federal Medicare program. Medicare designates a provider-based status to certain remote or satellite facilities that are not located in a BQA-licensed hospital. Facilities with a provider-based status (according to 42 CFR s. 413.65) receive Medicare's hospital reimbursement rates. Wisconsin Medicaid does not recognize Medicare's provider-based designation for these facilities, and therefore, services provided at these facilities are not reimbursed at Medicaid outpatient hospital rates.

Because Wisconsin Medicaid does not recognize Medicare's provider-based designation, claims for services provided at these facilities may *not* be submitted using a hospital's Medicaid provider number. Claims for services provided at a facility outside a Medicaid-certified and BQA-licensed hospital must be submitted using the Medicaid provider number of that outside facility. For example, when a claim is submitted by a freestanding facility that is outside, but affiliated with, a Medicaid-certified hospital or located on the same property as a Medicaid-certified hospital, the billing provider number of the freestanding facility must be indicated on the claim.

Providers are reminded that they are required to maintain Medicaid certification separately from the hospital, which includes maintaining a separate provider number, to be reimbursed for services provided in facilities outside hospital locations.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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